		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046086

Facility Name: Havana Health Care Center

Address: 609 N. Harpham (Number) Havana (City) 62644 (Zip Code)

County: Mason

Telephone Number: (309) 543-6121 **Fax #** (309) 543-1233

IDPA ID Number: 371346306008

Date of Initial License for Current Owners: 03/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,320	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,548	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,207	2,207	8
9	SNF/PED					9
10	ICF	19,235	5,862		25,097	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,235	5,862	2,207	27,304	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.12%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [Yes] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,207

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	130,367	18,163	2,320	150,850		150,850	5,946	156,796			1
2	Food Purchase		157,301		157,301		157,301	2	157,303			2
3	Housekeeping	80,400	8,795		89,195		89,195	25	89,220			3
4	Laundry	45,101	10,592		55,693		55,693		55,693			4
5	Heat and Other Utilities			88,311	88,311		88,311	539	88,850			5
6	Maintenance	30,520	31,782	6,889	69,191		69,191	3,262	72,453			6
7	Other (specify):* Mgmt. Co. Benefits							1,063	1,063			7
8	**TOTAL General Services**	286,388	226,633	97,520	610,541		610,541	10,837	621,378			8
	B. Health Care and Programs											
9	Medical Director			12,450	12,450		12,450		12,450			9
10	Nursing and Medical Records	917,878	60,685	350	978,913		978,913	12,454	991,367			10
10a	Therapy	72,097		7,826	79,923		79,923	5	79,928			10a
11	Activities	38,808	546	433	39,787		39,787	6	39,793			11
12	Social Services	21,826			21,826		21,826		21,826			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Benefits							1,262	1,262			15
16	**TOTAL Health Care and Programs**	1,050,609	61,231	21,059	1,132,899		1,132,899	13,727	1,146,626			16
	C. General Administration											
17	Administrative	64,240		267,991	332,231		332,231	(195,035)	137,196			17
18	Directors Fees											18
19	Professional Services			17,678	17,678		17,678	13,178	30,856			19
20	Dues, Fees, Subscriptions & Promotions			3,246	3,246		3,246	(851)	2,395			20
21	Clerical & General Office Expenses	28,451	6,380	34,142	68,973		68,973	44,737	113,710			21
22	Employee Benefits & Payroll Taxes			263,872	263,872		263,872		263,872			22
23	Inservice Training & Education			2,903	2,903		2,903	296	3,199			23
24	Travel and Seminar			800	800		800	1,596	2,396			24
25	Other Admin. Staff Transportation			5,293	5,293		5,293	3,067	8,360			25
26	Insurance-Prop.Liab.Malpractice			59,023	59,023		59,023	1,073	60,096			26
27	Other (specify):* Mgmt. Co. Benefits							12,375	12,375			27
28	**TOTAL General Administration**	92,691	6,380	654,948	754,019		754,019	(119,564)	634,455			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,429,688	294,244	773,527	2,497,459		2,497,459	(95,000)	2,402,459			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Havana Health Care Center #0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			96,772	96,772		96,772	14,602	111,374			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			163,542	163,542		163,542	6,025	169,567			32
33	Real Estate Taxes			62,550	62,550		62,550	394	62,944			33
34	Rent-Facility & Grounds							3,077	3,077			34
35	Rent-Equipment & Vehicles			5,749	5,749		5,749	108	5,857			35
36	Other (specify):*											36
37	**TOTAL Ownership**			328,613	328,613		328,613	24,206	352,819			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,024		39,024		39,024		39,024			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):* Nonallowable Costs			46,906	46,906		46,906	(46,906)				43
44	**TOTAL Special Cost Centers**		39,024	100,708	139,732		139,732	(46,906)	92,826			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,429,688	333,268	1,202,848	2,965,804		2,965,804	(117,700)	2,848,104			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,323)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(48)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,100)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,451)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,190)	43		28
29	Other-Attach Schedule	(32,751)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,963)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,737)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (76,737)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,700)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center

ID# 0046086

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (29,896)	43	1
2	X-Rays - Part A	(8,846)	43	2
3	Dues & Subscriptions	(1,438)	20	3
4	Depreciation Expense	9,287	30	4
5	Repairs & Maintenance	(452)	6	5
6	Medical Supplies	(608)	10	6
7	Office Supplies	(342)	21	7
8	Training & Education	(456)	23	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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28				28
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(32,751)		49

Havana Health Care Center
Provider #: 0046086
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Havana Health Care Center **#** 0046086 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	5,946	0	0	0	0	0	0	0	0	0	5,946	1
2	Food Purchase	0	2	0	0	0	0	0	0	0	0	0	2	2
3	Housekeeping	0	25	0	0	0	0	0	0	0	0	0	25	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	539	0	0	0	0	0	0	0	0	0	539	5
6	Maintenance	(452)	3,714	0	0	0	0	0	0	0	0	0	3,262	6
7	Other (specify):*	0	1,063	0	0	0	0	0	0	0	0	0	1,063	7
8	**TOTAL General Services**	(452)	11,289	0	0	0	0	0	0	0	0	0	10,837	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(608)	13,062	0	0	0	0	0	0	0	0	0	12,454	10
10a	Therapy	0	5	0	0	0	0	0	0	0	0	0	5	10a
11	Activities	0	6	0	0	0	0	0	0	0	0	0	6	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,262	0	0	0	0	0	0	0	0	0	1,262	15
16	**TOTAL Health Care and Programs**	(608)	14,335	0	0	0	0	0	0	0	0	0	13,727	16
	C. General Administration													
17	Administrative	0	(195,035)	0	0	0	0	0	0	0	0	0	(195,035)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,178	0	0	0	0	0	0	0	0	0	13,178	19
20	Fees, Subscriptions & Promotions	(1,438)	587	0	0	0	0	0	0	0	0	0	(851)	20
21	Clerical & General Office Expenses	(342)	0	45,079	0	0	0	0	0	0	0	0	44,737	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(456)	0	752	0	0	0	0	0	0	0	0	296	23
24	Travel and Seminar	0	0	1,596	0	0	0	0	0	0	0	0	1,596	24
25	Other Admin. Staff Transportation	0	0	3,067	0	0	0	0	0	0	0	0	3,067	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,073	0	0	0	0	0	0	0	0	1,073	26
27	Other (specify):*	0	0	12,375	0	0	0	0	0	0	0	0	12,375	27
28	**TOTAL General Administration**	(2,236)	(181,270)	63,942	0	0	0	0	0	0	0	0	(119,564)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,296)	(155,646)	63,942	0	0	0	0	0	0	0	0	(95,000)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Havana Health Care Center # 0046086 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,287	0	5,315	0	0	0	0	0	0	0	0	14,602	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48)	0	6,073	0	0	0	0	0	0	0	0	6,025	32
33	Real Estate Taxes	0	0	394	0	0	0	0	0	0	0	0	394	33
34	Rent-Facility & Grounds	0	0	3,077	0	0	0	0	0	0	0	0	3,077	34
35	Rent-Equipment & Vehicles	0	0	108	0	0	0	0	0	0	0	0	108	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,239	0	14,967	0	0	0	0	0	0	0	0	24,206	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(46,906)	0	0	0	0	0	0	0	0	0	0	(46,906)	43
44	**TOTAL Special Cost Centers**	(46,906)	0	0	0	0	0	0	0	0	0	0	(46,906)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,963)	(155,646)	78,909	0	0	0	0	0	0	0	0	(117,700)	45

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 5,946	$ 5,946	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	2	2	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	25	25	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	539	539	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,714	3,714	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,063	1,063	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13,062	13,062	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	5	5	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	6	6	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,262	1,262	10
11	V	17	Administrative	267,991	Petersen Health Care, Inc.	100.00%	72,956	(195,035)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	13,178	13,178	12
13	V	20	Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	587	587	13
14	Total			$ 267,991			$ 112,345	$ * (155,646)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 45,079	$ 45,079	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	752	752	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,596	1,596	17
18	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,067	3,067	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,073	1,073	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,375	12,375	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,315	5,315	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,073	6,073	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	394	394	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	3,077	3,077	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	108	108	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 78,909	$ * 78,909	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center
provider # 0046086
01/01/04 to 12/31/04

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,020,033	3	6.00	Salary	$ 72,956	L17,C8	1
2											2
3											3
4											4
5											5
6											6
7		See attached Schedule 7A									7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,956		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Havana Health Care Center
provider # 0046086
01/04/04 to 12/31/04

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	$ 89,079	$ 89,071	27,304	$ 5,946	1
2	2	Food	Patient Days	409,056	18	33		27,304	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		27,304	25	3
4	5	Utilities	Patient Days	409,056	18	8,082		27,304	539	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	27,304	3,714	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		27,304	1,063	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	27,304	13,062	7
8	10A	Therapy	Patient Days	409,056	18	75		27,304	5	8
9	11	Activities	Patient Days	409,056	18	86		27,304	6	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		27,304	1,262	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	27,304	72,956	11
12	19	Professional Services	Patient Days	409,056	18	197,418		27,304	13,178	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		27,304	587	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	27,304	45,079	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		27,304	752	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		27,304	1,596	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		27,304	3,067	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		27,304	1,073	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		27,304	12,375	19
20	30	Depreciation	Patient Days	409,056	18	79,620		27,304	5,315	20
21	32	Interest	Patient Days	409,056	18	90,987		27,304	6,073	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		27,304	394	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		27,304	3,077	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		27,304	108	24
25	TOTALS					$ 2,865,264	$ 1,919,411		$ 191,254	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	$3,179.00	08/31/02	$ 2,935,484	$ 2,842,990	08/01/07	varies	$ 152,565	1
2	Bank of Farmington		X	Van	$1,126.00	03/28/01	54,060	3,337	04/27/05	0.0750	2,210	2
3	Bank of Farmington		X	Car	$585.00	05/30/01	14,030	4,663	04/30/06	0.0750	574	3
4	Bank of Farmington		X	Jeep Cherokee	$228.00	06/30/04	7,332	6,222	08/08/07	0.0750	300	4
5												5
	Working Capital											
6	LaSalle Bank		X	Line of Credit	Interest	08/31/02	254,682		08/31/05	Varies	7,893	6
7												7
8												8
9	TOTAL Facility Related				$5,118.00		$ 3,265,588	$ 2,857,212			$ 163,542	9
	B. Non-Facility Related*											
10												10
11								Allocated from Management Co.			6,073	11
12								Less: Interest Income Offset			(48)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 6,025	14
15	TOTALS (line 9+line14)						$ 3,265,588	$ 2,857,212			$ 169,567	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 72,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 67,250	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,750)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Allocation from Management Co.** 394 **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 62,944	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000	63,650	9
2001	65,743	10
2002	68,754	11
2003	67,250	12

"Accrual = Prior year real estate taxes rounded to nearest 100."

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	005-3910000	Facility	$ 18.81	$ 18.81
2.	005-1479000	Facility	$ 67,231.14	$ 67,231.14
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,249.95	$ 67,249.95

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	418,945	2001	$ 200,000	1
2					2
3	TOTALS	418,945		$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2001	1971	$ 1,314,000	$ 47,251	35	$ 37,543	$ (9,708)	$ 131,400	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			2001	22,650	581	20	1,133	552	3,965	9
10	Flooring			2001	5,890	151	20	295	144	1,032	10
11	Landscaping			2001	8,984	768	20	449	(319)	1,572	11
12	A/C Heating Unit			2001	2,046	250	20	102	(148)	481	12
13	Fencing			2002	758	19	20	38	19	95	13
14	Roofing			2002	500	13	20	25	12	63	14
15	Ceiling Tiles			2003	9,516	71	20	476	405	714	15
16	Doors			2004	2,305	12	20	58	46	58	16
17	Nursing Station			2004	8,100	1,157	20	203	(954)	203	17
18	Furnace			2004	3,382	483	20	85	(398)	85	18
19	Water Heater			2004	2,281	326	20	57	(269)	57	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,380,412	$ 51,082		$ 40,464	$ (10,618)	$ 139,725	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 341,978	$ 42,960	$ 48,854	$ 5,894	7	$ 153,293	71
72	Current Year Purchases	29,312	4,291	2,095	(2,196)	7	2,095	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.		5,315	5,315				74
75	TOTALS	$ 371,290	$ 52,566	$ 56,264	$ 3,698		$ 155,388	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge Caravan	2001	$ 46,577	$ 5,366	$ 9,315	$ 3,949	5	$ 32,603	76
77	Facility Use	1999 Oldsmobile	2001	12,992	1,497	2,598	1,101	5	9,094	77
78	Facility Use	2001 Chevrolet	2003	10,002	3,200	2,000	(1,200)	5	3,000	78
79	Facility Use	1997 Jeep	2004	7,333	1,467	733	(734)		733	79
80	TOTALS			$ 76,904	$ 11,530	$ 14,646	$ 3,116		$ 45,430	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,028,606	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 115,178	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,374	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,804)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 340,543	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				3,077			5
6								6
7	TOTAL				$ 3,077 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,857 Description: Oxygen Tanks - $1,770; Copier Rental - $2,694; Postage Meter - $1,285; Mgmt. Allocation - $108
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(1)	2992 hrs	$ 65,909		$	$	2,992	$ 65,909	1
2	Licensed Speech and Language Development Therapist	10A(1)	206 hrs	6,188				206	6,188	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				29,424		29,424	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39(2)					9,600		9,600	13
14	TOTAL			$ 72,097		$	$ 39,024	3,198	$ 111,121	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center
Provider #: 0046086
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 287,588	$ 287,588	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,452,830	1,452,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,427	4,427	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,744,845	$ 1,744,845	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,380,412	1,380,412	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	448,194	448,194	16
17	Accumulated Depreciation (book methods)	(431,973)	(340,543)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,596,633	$ 1,688,063	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,341,478	$ 3,432,908	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 255,423	$ 255,423	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,476	62,476	30
31	Accrued Taxes Payable (excluding real estate taxes)	251	251	31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,300	67,300	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	67,797	67,797	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 453,247	$ 453,247	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,857,212	2,857,212	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,857,212	$ 2,857,212	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,310,459	$ 3,310,459	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,019	$ 122,449	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,341,478	$ 3,432,908	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Havana Health Care Center
Provider # 0046086
01/01/04 to 12/31/04

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities **Line 36, Other Current Liabilities (specify):**	Operating	After Consolidation
Accrued Vacation	67,217	67,217
Accrued Insurance	580	580
Total	67,797	67,797

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,003	1
2	Restatements (describe):		2
3			3
4	**Prior Period Adjustment**	(13,808)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,805)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,824	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 35,824	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,019	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,603,722	1
2	Discounts and Allowances for all Levels	(56,624)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,547,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	298,674	6
7	Oxygen	1,942	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 300,616	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,745	15
16	Rental of Facility Space		16
17	Sale of Drugs	61,894	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	66,581	20
21	Other Medical Services	3,473	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 134,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**	19,173	27
28	**See Attached Schedule 19A**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,173	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,001,628	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	610,541	31
32	Health Care	1,132,899	32
33	General Administration	754,019	33
	B. Capital Expense		
34	Ownership	328,613	34
	C. Ancillary Expense		
35	Special Cost Centers	85,930	35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,965,804	40
41	**Income before Income Taxes (line 30 minus line 40)****	35,824	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 35,824	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Havana Health Care Center
Provider # 0046086
01/01/04 to 12/31/04

Schedule 19A

XVII. INCOME STATEMENT

E. Other Revenue(specify):
Line 27, Settlement Income(Insurance, Legal, etc.)

Office Supplies Reimbursement	342
Repairs & Maintenance Refund	452
Training & Education Refund	456
Medical Supplies Refund	608
Prior Period Adjustment to Income	16,940
Miscellaneous Income	375
	19,173

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,576	1,628	$ 34,408	$ 21.14	1
2	Assistant Director of Nursing	2,080	2,080	35,101	16.88	2
3	Registered Nurses	6,528	6,744	116,758	17.31	3
4	Licensed Practical Nurses	13,808	14,301	221,055	15.46	4
5	Nurse Aides & Orderlies	44,637	46,138	444,710	9.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,199	3,241	72,097	22.25	7
8	Rehab/Therapy Aides	1,937	2,033	36,051	17.73	8
9	Activity Director	2,080	2,080	23,475	11.29	9
10	Activity Assistants	2,327	2,373	15,333	6.46	10
11	Social Service Workers	1,994	1,994	21,826	10.95	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,548	10.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,369	14,834	107,819	7.27	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	30,520	14.67	17
18	Housekeepers	9,258	9,685	80,400	8.30	18
19	Laundry	5,371	5,623	45,101	8.02	19
20	Administrator	2,080	2,080	64,240	30.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,080	2,080	28,451	13.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plan Coord.	1,993	1,993	29,795	14.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,477	123,067	$ 1,429,688 *	$ 11.62	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	12,450	L09, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	350	L10, C3	39
40	Physical Therapy Consultant	16	1,238	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	6,498	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultants	2	90	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	18	$ 20,626		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Showalter	Administrator	0	$ 64,240
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,240

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 267,991
TOTAL (agree to Schedule V, line 17, col. 3)	$ 267,991
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvois & Glasser	Accounting	$ 5,575
Bush, Snyder & Assoc.	Legal	315
Robert W. McQuellon	Appraisal	2,500
ADP	Computer Services	7,008
Arch Wireless	Computer Services	239
IVANS	Computer Services	603
LTC Solutions	Computer Services	1,320
AdminaStar Federal	Computer Services	118
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,095
Unemployment Compensation Insurance	18,046
FICA Taxes	106,099
Employee Health Insurance	70,127
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401-K Matching	4,348
Employee Relations	9,157
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,872

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	285
Health Care Worker Background Check	
(Indicate # of checks performed 5)	60
Various Licenses	1,043
Various Dues & Subscriptions	1,858
Allocated from Management Co.	587
Less: Public Relations Expense	(1,438)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,395

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	800
Allocated from Management Co.	1,596
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,396

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center
Provider # 0046086
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	17,678
Allocated from Management Company - Legal	2,155
Allocated from Management Company - Other	11,023
Total (agree to Schedule V, line 19, column 8)	30,856

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center **#** 0046086 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,802**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		130,367	18,163	2,320	150,850	0	150,850	5,946	156,796
2. Food Purchase		0	157,301	0	157,301	0	157,301	2	157,303
3. Housekeeping		80,400	8,795	0	89,195	0	89,195	25	89,220
4. Laundry		45,101	10,592	0	55,693	0	55,693	0	55,693
5. Heat and Other Utilities		0	0	88,311	88,311	0	88,311	539	88,850
6. Maintenance		30,520	31,782	6,889	69,191	0	69,191	3,262	72,453
7. Other (specify)*		0	0	0	0	0	0	1,063	1,063
8. Total General Services		286,388	226,633	97,520	610,541	0	610,541	10,837	621,378
9. Medical Director		0	0	12,450	12,450	0	12,450	0	12,450
10. Nursing & Medical Records		917,878	60,685	350	978,913	0	978,913	12,454	991,367
10a. Therapy		72,097	0	7,826	79,923	0	79,923	5	79,928
11. Activities		38,808	546	433	39,787	0	39,787	6	39,793
12. Social Services		21,826	0	0	21,826	0	21,826	0	21,826
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	1,262	1,262
16. Total Health Care & Programs		1,050,609	61,231	21,059	1,132,899	0	1,132,899	13,727	1,146,626
17. Administrative		64,240	0	267,991	332,231	0	332,231	-195,035	137,196
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	17,678	17,678	0	17,678	13,178	30,856
20. Fees, Subscriptions & Promotion		0	0	3,246	3,246	0	3,246	-851	2,395
21. Clerical & General Office		28,451	6,380	34,142	68,973	0	68,973	44,737	113,710
22. Employee Benefits & Payroll		0	0	263,872	263,872	0	263,872	0	263,872
23. Inservice Training & Education		0	0	2,903	2,903	0	2,903	296	3,199
24. Travel and Seminar		0	0	800	800	0	800	1,596	2,396
25. Other Admin. Staff Trans		0	0	5,293	5,293	0	5,293	3,067	8,360
26. Insurance-Prop.Liab.Malpractice		0	0	59,023	59,023	0	59,023	1,073	60,096
27. Other (specify)*		0	0	0	0	0	0	12,375	12,375
28. Total General Adminis		92,691	6,380	654,948	754,019	0	754,019	-119,564	634,455
29. Total General Administrative		1,429,688	294,244	773,527	2,497,459	0	2,497,459	-95,000	2,402,459
30. Depreciation		0	0	96,772	96,772	0	96,772	14,602	111,374
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	163,542	163,542	0	163,542	6,025	169,567
33. Real Estate		0	0	62,550	62,550	0	62,550	394	62,944
34. Rent - Facility & Grounds		0	0	0	0	0	0	3,077	3,077
35. Rent - Equipment & Vehicles		0	0	5,749	5,749	0	5,749	108	5,857
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	328,613	328,613	0	328,613	24,206	352,819
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	39,024	0	39,024	0	39,024	0	39,024
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	53,802	53,802	0	53,802	0	53,802
43. Other (specify):*		0	0	46,906	46,906	0	46,906	-46,906	0
44. Total Special Cost Ce		0	39,024	100,708	139,732	0	139,732	-46,906	92,826
45. Grand Total		1,429,688	333,268	1,202,848	2,965,804	0	2,965,804	-117,700	2,848,104

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	287,588	287,588
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,452,830	1,452,830
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	4,427	4,427
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,744,845	1,744,845
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	200,000	200,000
14. Buildings, at Historical Cost	1,380,412	1,380,412
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	448,194	448,194
17. Accumulated Depreciation (book methods)	-431,973	-340,543
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,596,633	1,688,063
25. Total Assets	3,341,478	3,432,908
CURRENT LIABILITIES		
26. Accounts Payable	255,423	255,423
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	62,476	62,476
31. Accrued Taxes Payable	251	251
32. Accrued Real Estate Taxes	67,300	67,300
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	67,797	67,797
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	453,247	453,247
LONG TERM LIABILITES		
39.Long-Term Notes Payable	2,857,212	2,857,212
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	2,857,212	2,857,212
46.Total Liabilities	3,310,459	3,310,459
47.Total Equity	31,019	122,449
48.Total Liabilities and Equity	3,341,478	3,432,908

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,603,722
2. Discounts and Allowances for all Levels	-56,624
Subtotal - Inpatient Care	2,547,098
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	298,674
7. Oxygen	1,942
Subtotal - Anciliary Revenue	300,616
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	2,745
16. Rental of Facility Space	0
17. Sale of Drugs	61,894
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	66,581
21. Other Medical Services	3,473
22. Laundry	0
Subtotal - Other Operating Revenue	134,693
24. Contributions	0
25. Interest and Other Investments Income	48
Subtotal - Non-Operating Revenue	48
27. Other Revenue (specify):	19,173
28. Other Revenue (specify):	0
Subtotal - Other Revenue	19,173
30. Total Revenue	3,001,628
31. General Services	610,541
32. Health Care	1,132,899
33. General Administration	754,019
34. Ownership	328,613
35. Special Cost Centers	85,930
35. Provider Participation Fee	53,802
37. Other	0
40. Total Expenses	2,965,804
41. Income Before Income Taxes	35,824
42. Income Taxes	0
43. Net Income or Loss for the Year	35,824

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